TO: [Name of doctor, provider, hospital, clinic, facility]

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Dates of Treatments:_____ Purpose of Disclosure: custody litigation discovery

I authorize and consent to the release and disclosure by the above named medical provider of medical records/information to [name and address of attorney]. In addition to the general authorization to release the records, I further authorize the medical provider listed above to provide information from the following confidential records:

> RECORDS OF TREATMENT OR HISTORY OF DRUG OR ALCOHOL ABUSE OR PSYCHIATRIC ILLNESS. Confidential information relating to mental health and/or alcohol/drug use under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of amendments of 1974 (P.L. 93-282) and Veteran's Omnibus Health Care Act of 1976 (P.L. 92-94-581).

Extent of Information to be disclosed: *(Check each item to be provided.)*

__History & Physical	___Pathology Reports	___X-ray Reports	__Discharge Summary	___Laboratory Report	___Behavioral Health
___Psychological Hist.	__Substance Abuse (alcohol/drug)	___Summary of Involvement	___Psychological Testing	___Operative Reports	___EKG Reports
___Specify:_____					

Name and address of company or persons authorized to receive information:

Attorney Name and address and phone

Company/Person/Facility *Address* *Phone Number*

This authorization shall be considered invalid after one year (or 90 days with respect to drug and alcohol abuse records) from the date of signing. I may revoke this authorization at any time by providing written notice of revocation. I may not revoke the authorization retroactively for information already released. With respect to any drug and alcohol abuse treatment information protected by federal confidentiality rules and released pursuant to this authorization, or records regarding communicable disease related information, the recipient of this information understands that it is prohibited to make any further disclosure of this information unless further disclosure of this information is expressly permitted by written consent or the undersigned or otherwise permitted by applicable law.

_____ _____

Date of Consent Patient Signature or Authorized Party